

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and cemetery filled in by the funeral director, TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06649

6658

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elsie Barnett (Elsie May Barnett)		4. DATE OF DEATH June 8 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 6	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Dillman		14. MOTHER'S MAIDEN NAME Corvilla Scarborough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles H. Barnett		Address Elkton Rd Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 1959 to June 8 1959 , that I last saw the deceased alive on June 7 1959 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Milford H. Sprecher M.D.		DATE SIGNED June 8 1959	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-12-1959	22c. NAME OF CEMETERY OR CREMATORY Leeds Methodist	22d. LOCATION (City, town, or county) (State) Elkton Rural Cecil Co., Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph B. Grant		ADDRESS North East, Maryland	
24a. REC'D BY REGISTRAR JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Grant	

42

1000 10000

$$\|u\|_{L^2(\mathbb{R}^n)}^2 = \int_{\mathbb{R}^n} |u|^2 dx = \int_{\mathbb{R}^n} |u|^2 dx = 0$$

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

454-74-1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6672 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Item 8 FilmG243 6-15-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Jacob Middle Robert Last Becker				4. DATE OF DEATH Month 6 Day 5 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-1889 1890		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Roofing and siding		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No information				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 133-03-2091		17. INFORMANT Address Mrs. Jacob R. Becker, Rising Sun, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured neck and punctured left upper lobe of 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Lung. (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of window onto bath tub					
20c. TIME OF INJURY Month, Day, Year 6 5 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rising Sun Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE: R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		6-6-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-59		22c. NAME OF CEMETERY OR CREMATORY Porters BRIDGE CEM.		22d. LOCATION (City, town, or county) (State) Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed				ADDRESS Rising Sun Md.		24a. REC'D BY REGISTRAR DATE JUN 10 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

NEW YORK STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		35		Male		White		1945-10-15		New York City	
Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status	
Heart Disease		Natural		Teacher		High School		Catholic		Married	
Medical History		Previous Illnesses		Present Illnesses		Treatment		Post-mortem Examination		Remarks	
Hypertension		Myocardial Infarction		Coronary Artery Disease		Medication		No significant findings		No significant findings	
Family History		Social History		Habitual Habits		Environmental Factors		Autopsy		Disposition of Body	
None		None		None		None		No		Buried	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Medical Officer		Signature of Health Officer		Signature of Registrar	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and camp... TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and camp... page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6673

CERTIFICATE OF DEATH

06651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank Bennett				4. DATE OF DEATH Month Day Year June 29 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 14, 1870 89rs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles H. Bennett				14. MOTHER'S MAIDEN NAME Rachael Buckworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 184-22-1774		17. INFORMANT Address Alice R. Bennett Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 days some years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 10, 1958, to June 29, 1959, that I last saw the deceased alive on June 28, 1959, and that death occurred at 7:10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Chesapeake City, Md. 6/30/59 ACTUAL SIGNATURE H. Davis M.D. PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-1959		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				ADDRESS Chesapeake City, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraye			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6674

CERTIFICATE OF DEATH

06652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City			c. LENGTH OF STAY IN 1b Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION George St.				d. STREET ADDRESS George St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM K. BORGER				4. DATE OF DEATH Month Day Year June 3, 19 59			
5. SEX M.	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 15, 1877		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store-keeper		10b. KIND OF BUSINESS OR INDUSTRY Sales		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Borger				14. MOTHER'S MAIDEN NAME Catherine Schrope			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 219-34-4654		17. INFORMANT Mrs. Annie M. Borger		Address Ches. City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Cirrhosis of liver. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition anemia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 10, 19 58, to June 3, 19 59, that I last saw the deceased alive on June 2, 19 59, and that death occurred at 5:00 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Davis			M.D. Chesapeake City, Md.			DATE SIGNED 6/4/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Augustine		22d. LOCATION (City, town, or county) (State) St. Augustine, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home Donald E. Pippin Elkton, Md.				24a. REC'D BY REGISTRAR DATE JUN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Sex _____		Age _____	
Race _____		Birth Date _____	
Place of Birth _____		Date of Birth _____	
Usual Residence _____		Date of Death _____	
Cause of Death _____		Date of Death _____	
Place of Death _____		Date of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	

1

6659 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G244 7-14-59 et
CERTIFICATE OF DEATH

06653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Columbia Middle Boyer Last Unknown		4. DATE OF DEATH Month June Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME U⁴ known		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nellie Washington		Address Cecilton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heat exhaustion.			INTERVAL BETWEEN ONSET AND DEATH unknown years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1 , 19 59 , to 30 June 59 , 19 59 , that I last saw the deceased alive on June 30 , 19 59 , and that death occurred at 9:15p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecilto, Md. DATE SIGNED 3 July 59			
ACTUAL SIGNATURE Wallace Obenshain M.D. Cecilto, Md.			
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 4, 59	22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery	22d. LOCATION (City, town, or county) (State) Cecilton Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		24a. REC'D BY REGISTRAR July 7 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Hume

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

4-29

Name of deceased		Sex		Age		Date of birth		Place of birth	
John Doe		Male		45		Jan 15, 1900		Baltimore, Md.	
Cause of death		Manner of death		Occupation		Education		Religion	
Heart disease		Natural		Teacher		High School		Roman Catholic	
Date of death		Time of death		Place of death		Physician		Hospital	
April 28, 1945		10:30 AM		Home		Dr. J. H. Smith		St. Mary's Hospital	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of funeral director	
J. H. Smith		A. B. Jones		M. C. Brown		D. E. White		F. G. Black	
Official use		Official use		Official use		Official use		Official use	
Seal of Registrar		Seal of Registrar		Seal of Registrar		Seal of Registrar		Seal of Registrar	

6675

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
				f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Thomas Boyer				4. DATE OF DEATH Month Day Year 6 11 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-28-1877		9. AGE (In years last birthday) yrs. 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Boyer				14. MOTHER'S MAIDEN NAME Mary Louise Biddle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-24-7693		17. INFORMANT Elsie V. Reed		Address Elkton Rd Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-VASCULAR FAILURE 104X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) UREMIA DUE TO (c) Ca. of G.I. TRACT (COLON)							INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 2 DAYS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS / ARTERIOSCLEROTIC (CARDIOVASC. DIS.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 7, 1959 to JUNE 11, 1959 , that I last saw the deceased alive on JUNE 10, 1959 , and that death occurred at 3:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecil Ave. DATE SIGNED 6-11-59 ACTUAL SIGNATURE Luis M. Cuza M.D. NORTH EAST Md. PHYSICIAN'S NAME (Type) Luis M. Cuza							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-15-1959		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East Cecil Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



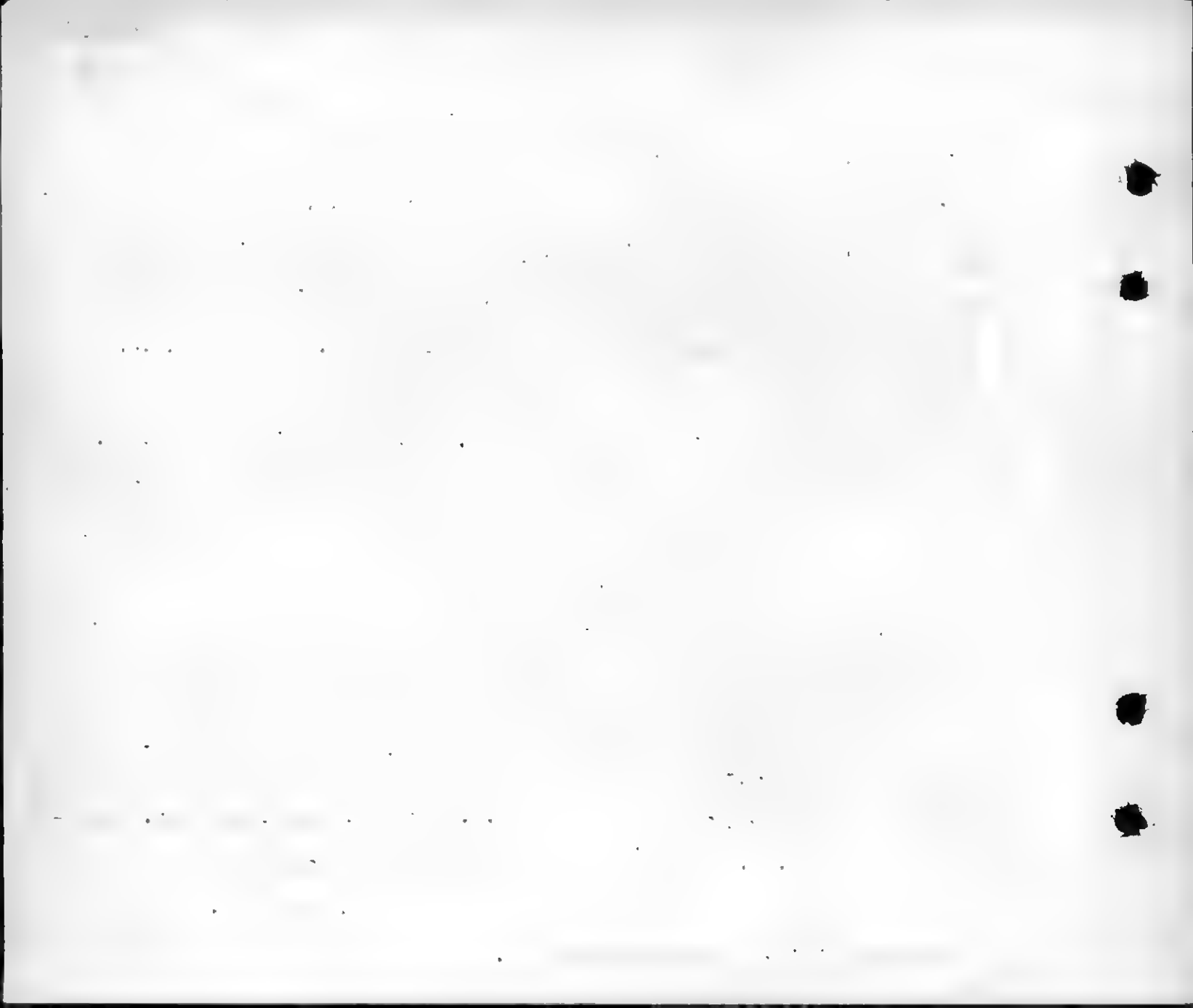
6676

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Livingston Middle (NMI) Last Burgess		4. DATE OF DEATH Month 6 Day 19 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-13-92
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Charles Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Burgess		14. MOTHER'S MAIDEN NAME Corn Posey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. INFORMANT Address Not ascertainable Hosp. Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism, massive DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of left femoral vein DUE TO (c) Herniorrhaphy left 6-16-59		INTERVAL BETWEEN ONSET AND DEATH within 30 min. unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-10 , 19 59 , to 6-19 , 19 59 , and that death occurred at 8:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. L. Garey</i>		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 6-22-59	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6-23-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Ft. Myers, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital. The attending physician, after the death certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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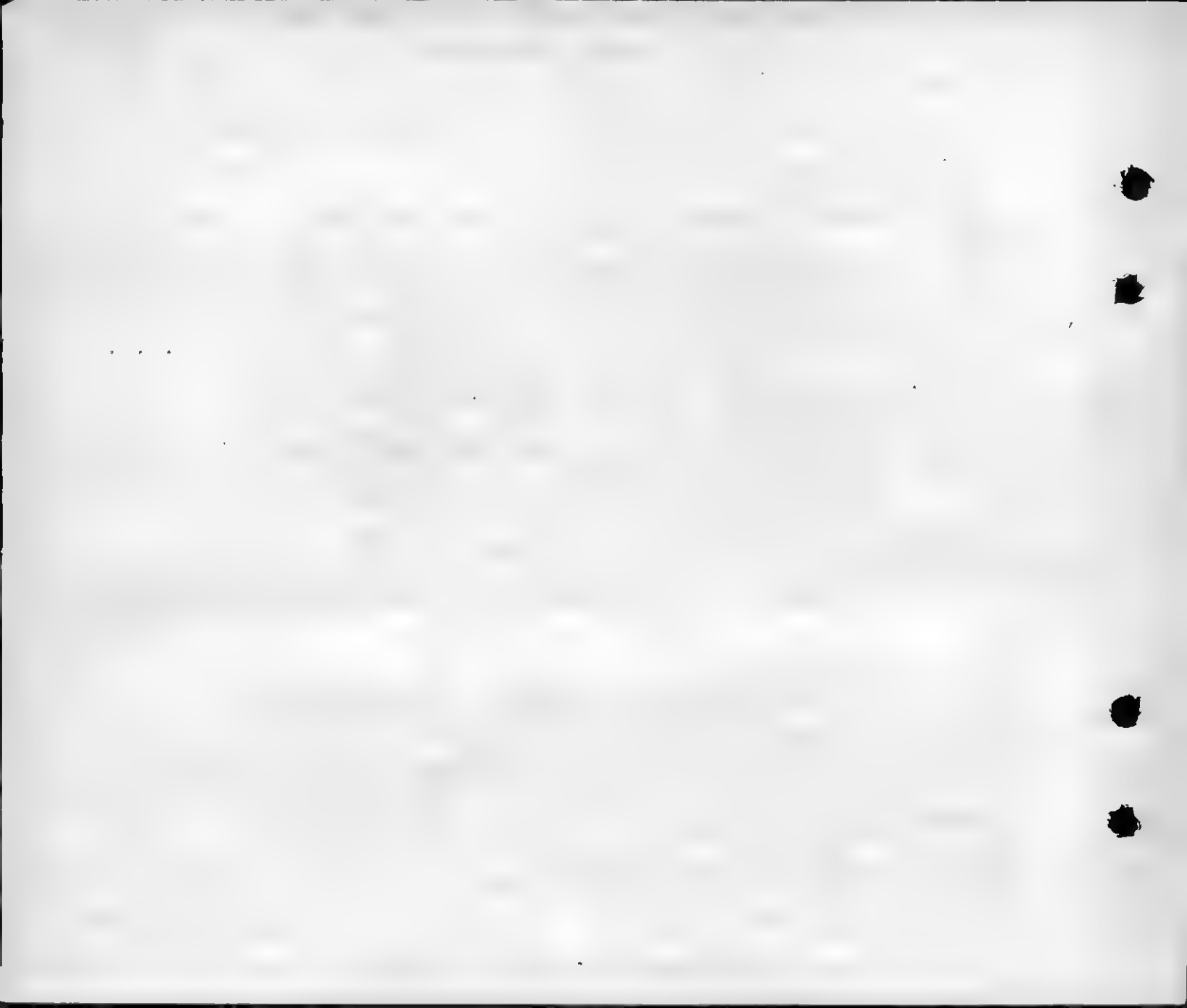
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenton 46 x	
f. STREET ADDRESS None		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last Leathe S. Cahall		4. DATE OF DEATH Month Day Year June 26 1959	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jackson		14. MOTHER'S MAIDEN NAME Frances Ann Cahall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Fred Cahall		Address Kenton, Delaware	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6/26	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1959, to June 26, 1959, that I last saw the deceased alive on June 25, 1959, and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Dr. Fred H. Green</u> M.D.		DATE SIGNED <u>June 26, 1959</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/59	
22c. NAME OF CEMETERY OR CREMATORY Templeville		22d. LOCATION (City, town, or county) (State) Templeville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais</u> ADDRESS <u>Greensboro Md.</u>		24a. REC'D BY REGISTRAR DATE JUN 29 '59	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the funeral director must fill in the remaining pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

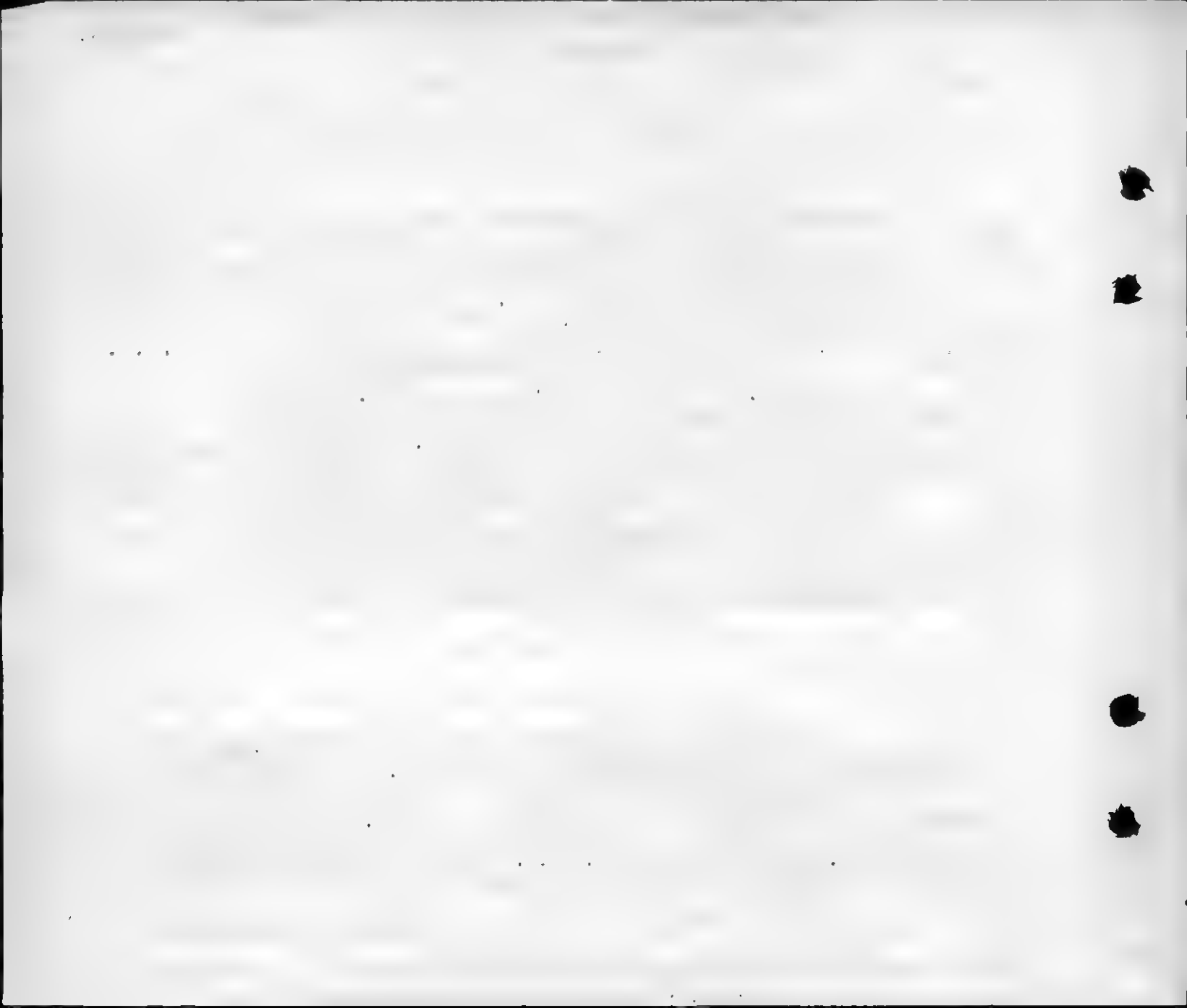
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1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chesapeake City		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
3. NAME OF DECEASED (Type or print) First ROLAND Middle A. Last COOLING		4. DATE OF DEATH Month June Day 15 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1906
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY C. and D. Canal	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Cooling		14. MOTHER'S MAIDEN NAME Mary E. Arrants	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Gertrude H. Cooling		Address Chesapeake City	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary occlusion DUE TO (b) Arteriosclerotic coronary artery disease DUE TO (c) with angina pectoris Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH none unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 19 54, to June 15 19 59, that I last saw the deceased alive on June 1 19 59, and that death occurred at 8 a.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.		ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 6/16/59	
PHYSICIAN'S NAME (Type) S. RALPH A. ANDREWS, JR., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/18/1959	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pinpin Funeral Home, 1414 N. Elkton, Md.		24a. REC'D BY REGISTRAR DATE JUN 22 '59	24b. REGISTRAR'S SIGNATURE Charles S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, remove 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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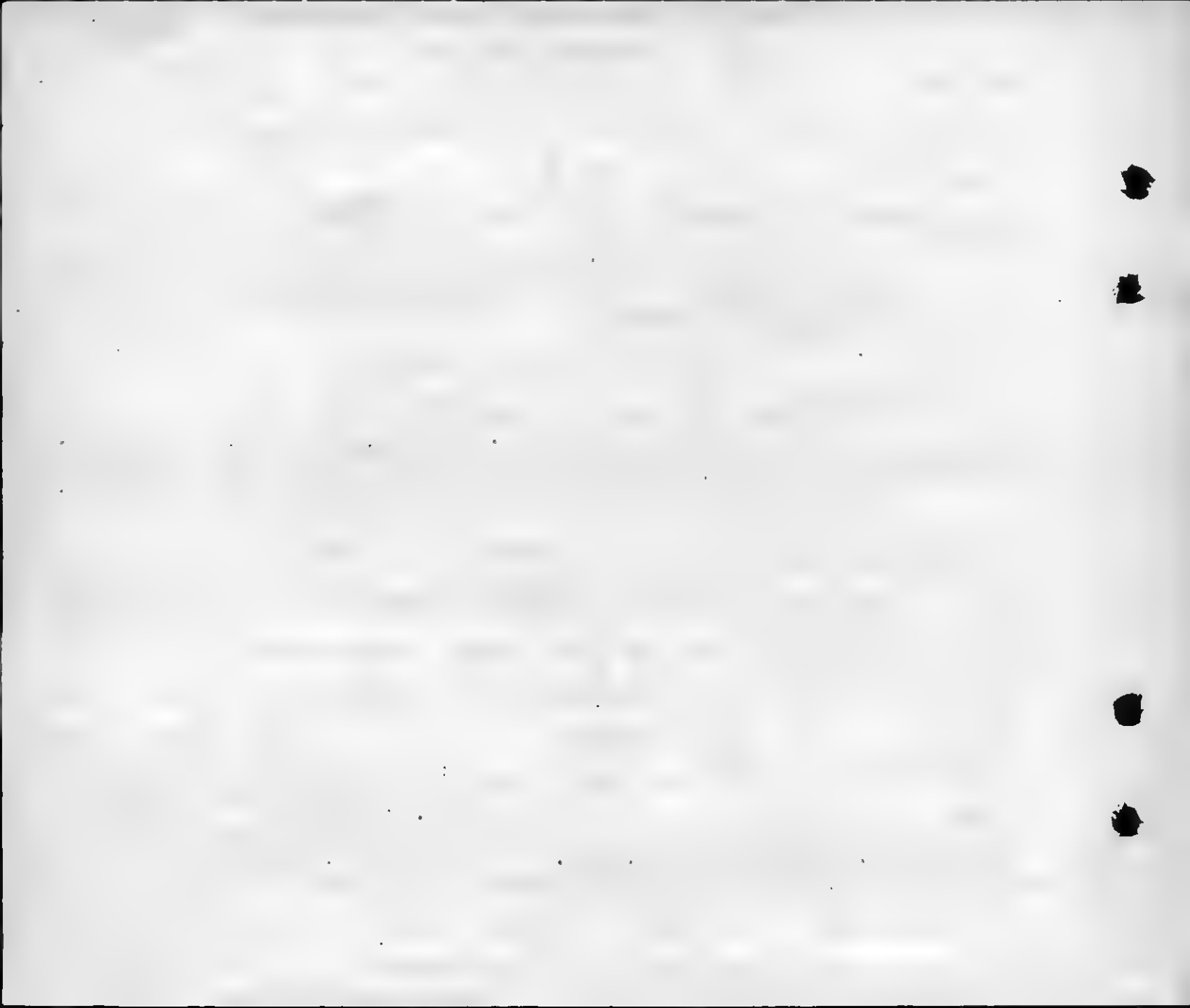
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>Corriden</u>		4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DuPont Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Corriden</u>		14. MOTHER'S MAIDEN NAME <u>Anna Coizer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-3864</u>	
17. INFORMANT <u>Mrs. Grace S. Corriden</u>		Address <u>Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident with coma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>22 da ys</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 10</u> 19 <u>59</u> to <u>JUNE 12</u> 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 11</u> 19 <u>59</u> , and that death occurred at <u>11:45p</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>6/13/59</u>	
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		<u>Elkton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>
23. FUNERAL/DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6678

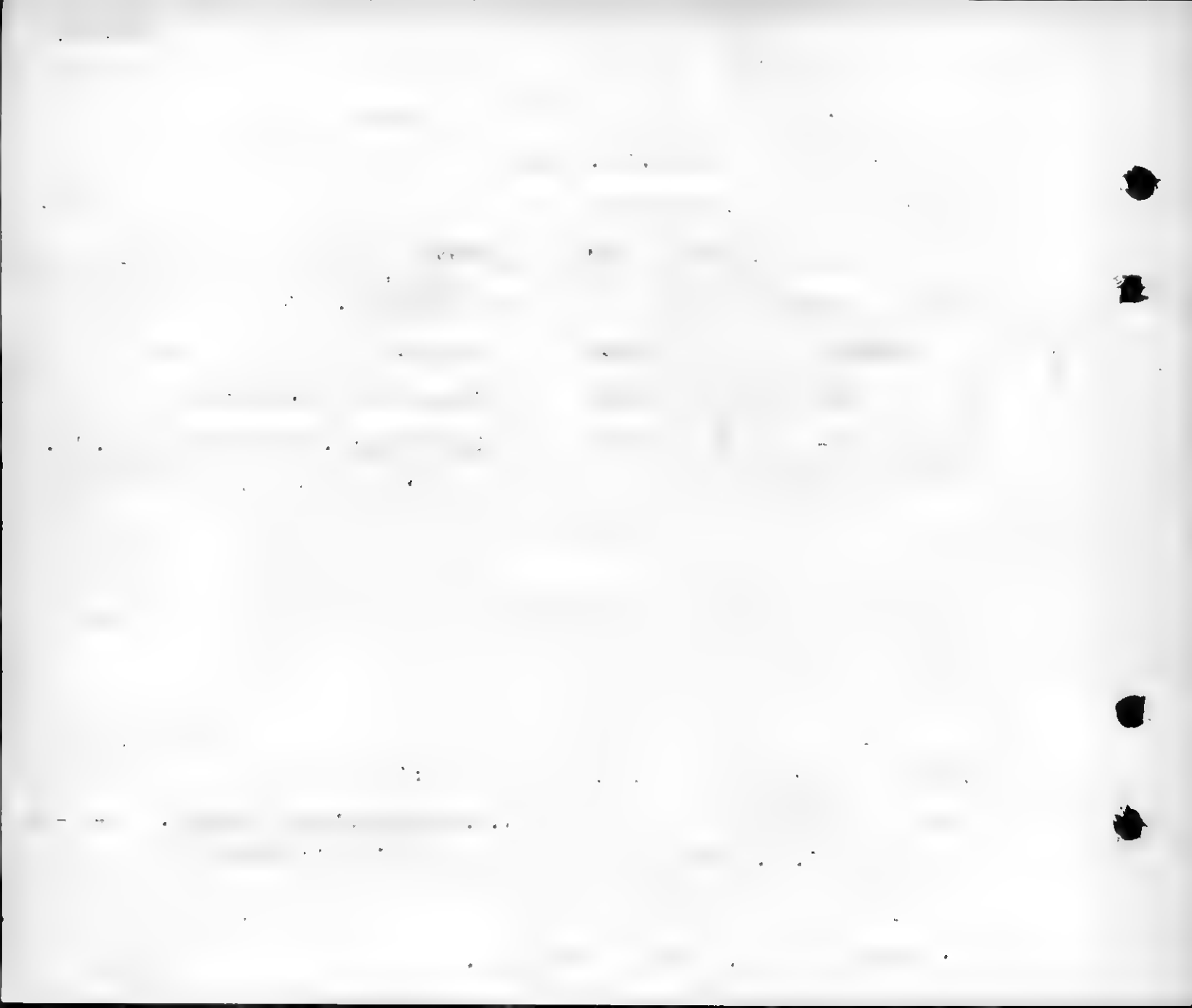
CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN lb 20yrs. 7mo. 27days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SHERMAN Middle (NMI) Last DIZE		4. DATE OF DEATH Month June Day 22 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (Day and Month and Year) 1892 Month unk.
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dredger		10b. KIND OF BUSINESS OR INDUSTRY Oyster	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Dize (deceased)		14. MOTHER'S MAIDEN NAME Maggie Evans (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW-I	
17. INFORMANT Not available		Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.5 DUE TO Bronchopneumonia right lower lobe, unresolved Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease, Severe (c) Unknown			INTERVAL BETWEEN ONSET AND DEATH 7 to 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized & cerebral, severe			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 26, 1938 to June 22, 1959 from the causes and on the date stated above.			
ACTUAL SIGNATURE J. L. GAREY		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) J. L. GAREY		DATE SIGNED 6-23-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 6/24/59	
22c. NAME OF CEMETERY OR CREMATORY Crisfield		22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur G. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6679

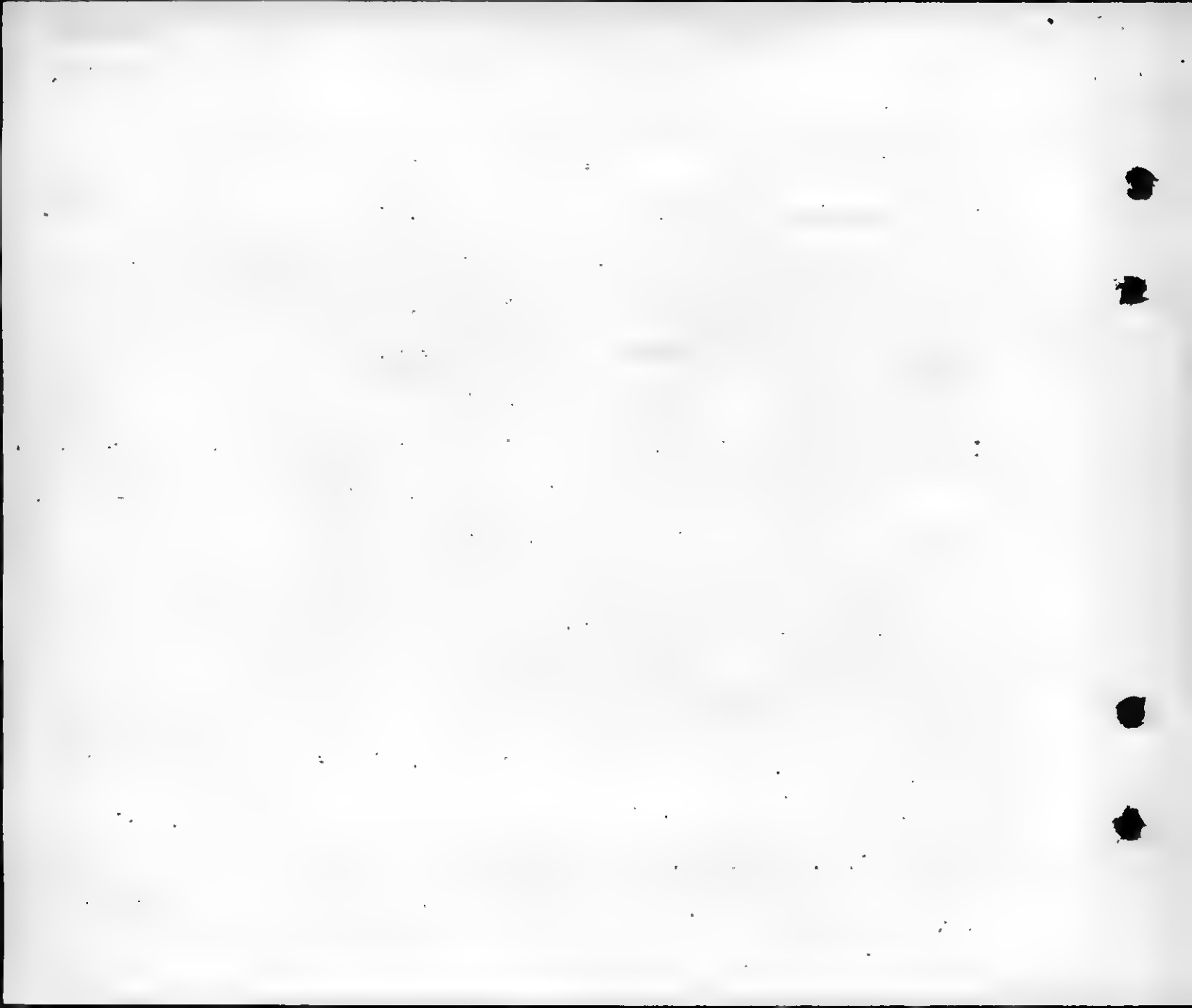
CERTIFICATE OF DEATH

06660

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
c. LENGTH OF STAY IN 1b 7yrs5mos24days		d. STREET ADDRESS 604 Market	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTHER Middle E. Last DRYDEN		4. DATE OF DEATH Month June Day 13 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1876
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Registered	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM TUMBLIN DRYDEN		14. MOTHER'S MAIDEN NAME LYDIA CANNON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe.			
INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 21, 1951 to June 13, 1959 and that death occurred at 3:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. L. GAREY		DATE SIGNED 6-14-59	
PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.		ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 6-14-59	22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S EPISCOPAL	22d. LOCATION (City, town, or county) (State) POCOMOKE CITY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Arthur R. Watson		24a. REC'D BY REGISTRAR JUN 19 '59	
ADDRESS 14001 FULTON HO E, Pocomoke City, Maryland		24b. REGISTRAR'S SIGNATURE Arthur R. Watson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6662

CERTIFICATE OF DEATH

06661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gilbert Middle Edwards Last Edwards			4. DATE OF DEATH Month June Day 28 Year 19 59				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY General Labor		11. BIRTHPLACE (State or foreign country) Earleville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilbert Edwards Sr.				14. MOTHER'S MAIDEN NAME Elizabeth Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 155-09-0300		17. INFORMANT Phillip Edwards 40 Pershing Ave. Cartert, N.J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 days year.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, Diabetes mellitus (Hepato-renal failure?)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <input type="checkbox"/> p. m. <input type="checkbox"/> 19 <input type="checkbox"/>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 26 , 19 59 , to June 28 , 19 59 , that I last saw the deceased alive on June 28 , 19 59 , and that death occurred at 1:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace O'Brien			ADDRESS (Street, city or town, state) Cecilton, Md.			DATE SIGNED 1 July 59	
PHYSICIAN'S NAME (Type) WALLACE O'BRIEN			CECILTON, MD.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 2, 59		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		22d. LOCATION (City, town, or county) (State) Cecilton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Pellmar				ADDRESS Millington Md.		24a. REC'D BY REGISTRAR DATE III 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

Cerebro-vascular Acc.
Cerebral Atherosclerosis.

11. Mrs (Hypertension) failed.

201
Jan 28
1937
C.M.B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

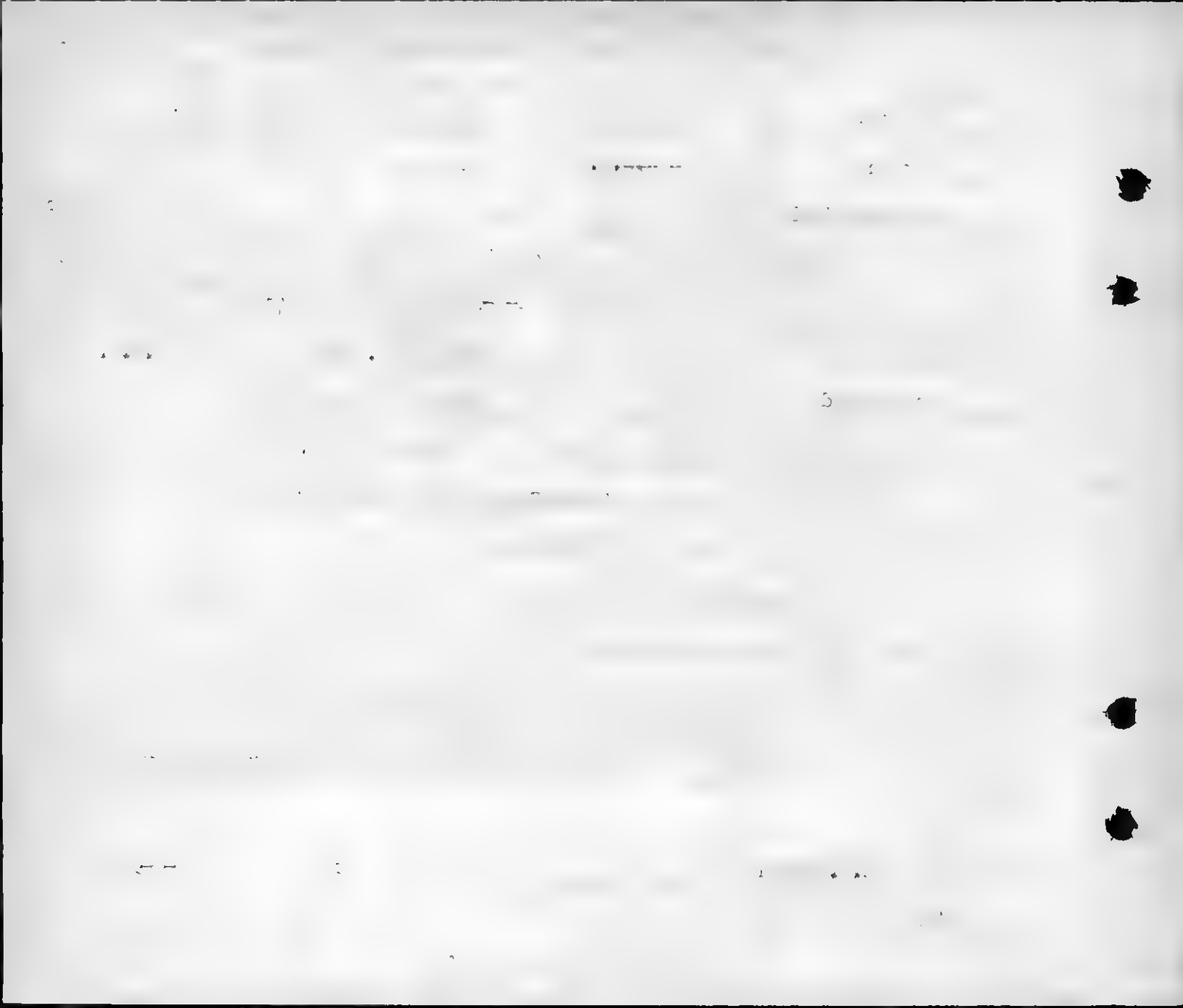
6663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk Mills</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Forester</u>			4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1959</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-9-1888</u>			
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keeping house</u>		11. BIRTHPLACE (State or foreign country) <u>Johnson Co. Tenn</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Scott Head</u>					
14. MOTHER'S MAIDEN NAME <u>May Forester</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT Address <u>Denver Forrester, R.D.# 1, Elkton, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anast Accident Conoary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		DATE SIGNED <u>6-4-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-8-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Elkton, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u>					
24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

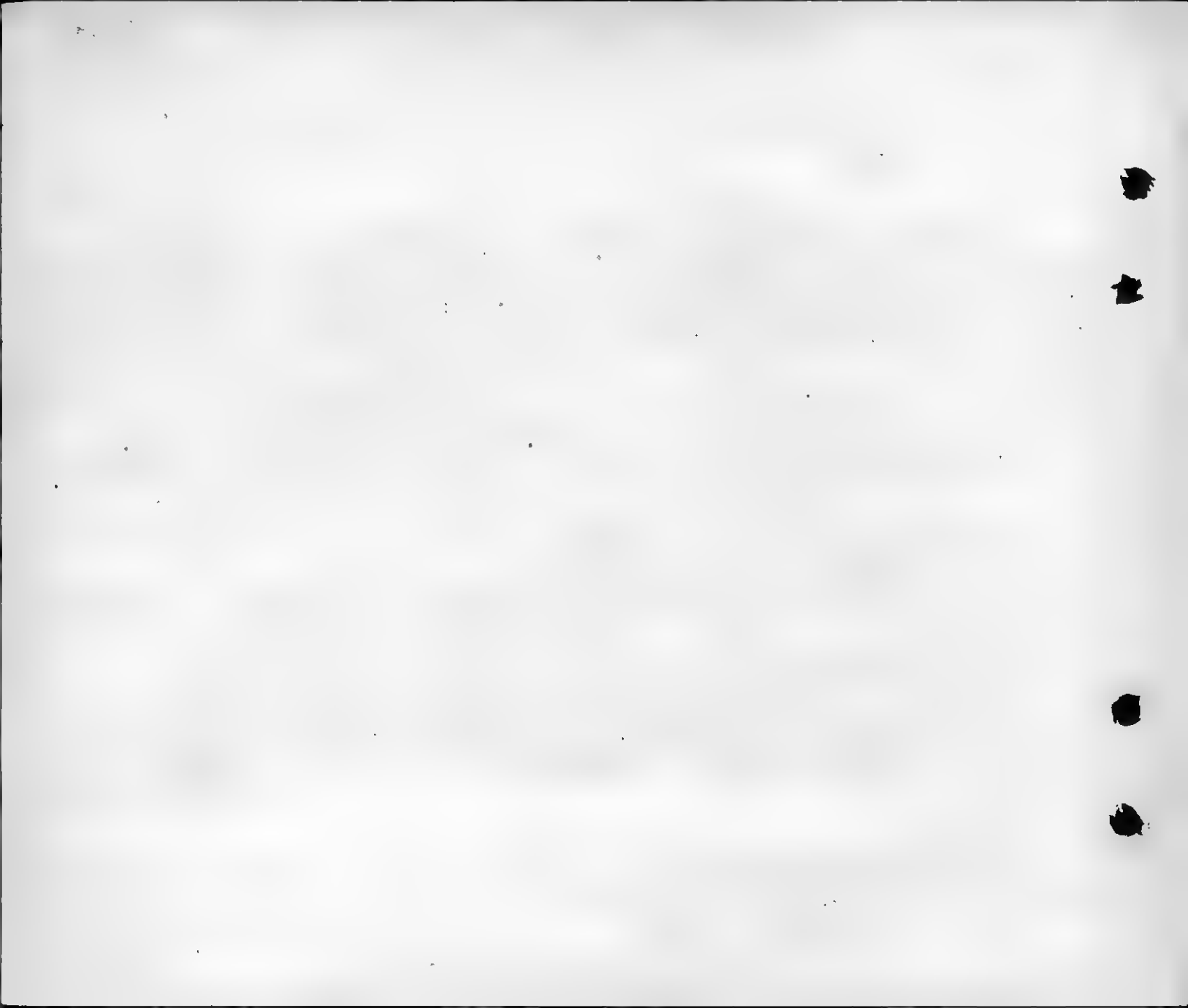
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6664 Item 9 File #244 6-25-59 et
CERTIFICATE OF DEATH

06663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Cecil b. COUNTY Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
c. LENGTH OF STAY IN 1b 1 Week		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month 6 Day 19 Year 1959	
3. NAME OF DECEASED (Type or print) First Middle Last Betty J. Gross	5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 14, 1916 9. AGE (In years last birthday) 42 1/2 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sinnett J. Justice		14. MOTHER'S MAIDEN NAME Lilly Belle Justice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Donna Batalis		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal CARCINOMATOSIS 1750 DUE TO (b) Carcinoma of ovary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS 12 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/10, 1959, to 6/19, 1959, that I last saw the deceased alive on 6/18, 1959, and that death occurred at 5:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Fischer		ADDRESS (Street, city or town, state) 162 W MAIN ST. DATE SIGNED 6/19/59	
PHYSICIAN'S NAME (Type) John A. Fischer		ELKTON, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6/19/59	22c. NAME OF CEMETERY OR CREMATORY Radfield Cem. Welch, West Virginia	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE PIP IN FUNERAL HOME Donald M. Bee		24a. REC'D BY REGISTRAR DATE JUN 22 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



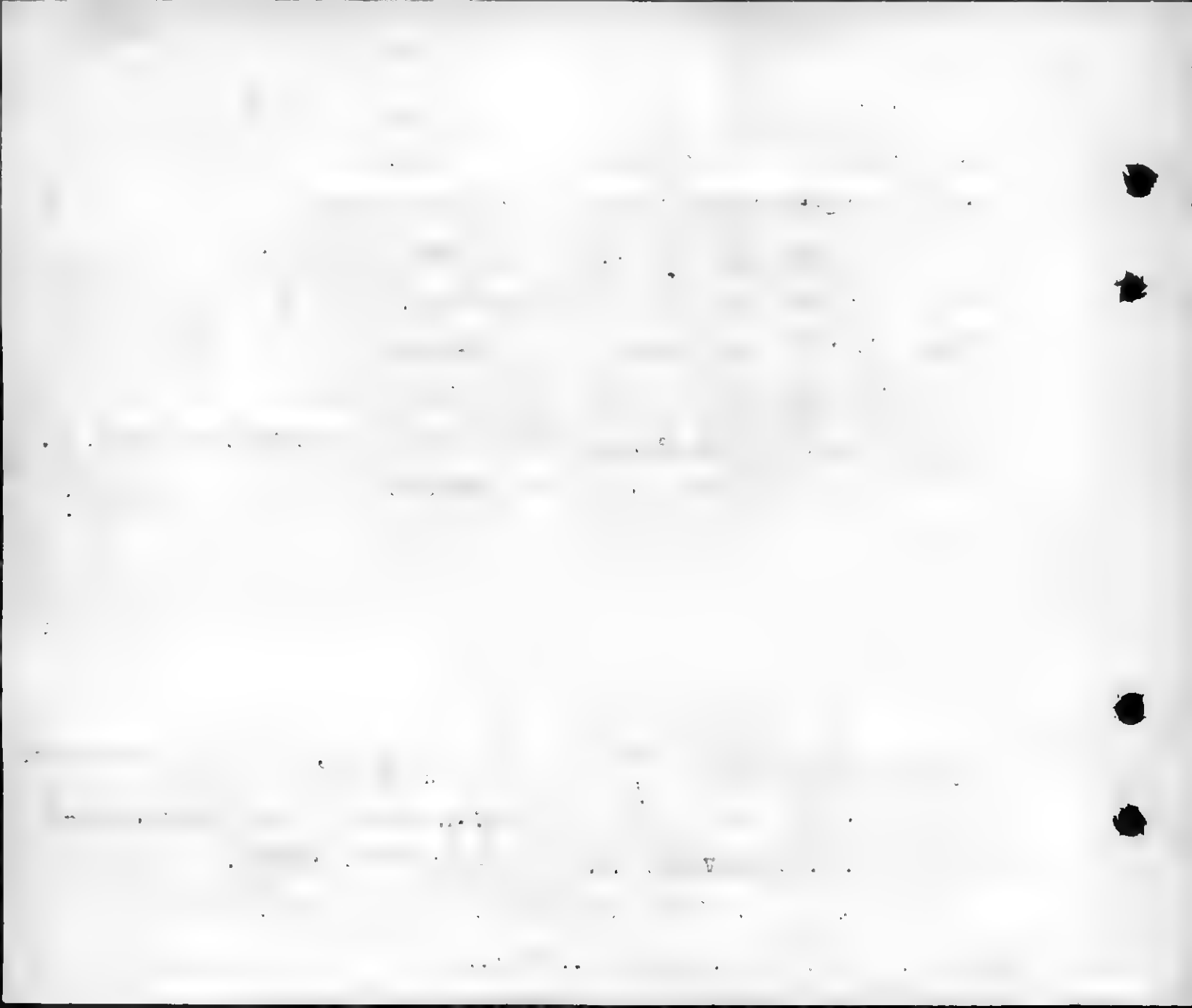
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6680
CERTIFICATE OF DEATH

06664
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 30 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2703 Baker Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last GROSS		4. DATE OF DEATH Month June Day 25 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 9, 1919
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Gross		14. MOTHER'S MAIDEN NAME Elizabeth Sisco	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. 19 03 3489	
INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 155.0 Cancer of the Liver (Hepatoma) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Approx. 2 mths.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 26, 1959 , to June 25, 1959 , and that death occurred at 2:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Perry Point, Md. 6-25-59			
ACTUAL SIGNATURE J. R. Garcia-Velez M.D.		M.D. V. A. Hospital, Perry Point, Md. 6-25-59	
PHYSICIAN'S NAME (Type) J. R. GARCIA-VELEZ, M.D.		Perry Point, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/30/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George E. Kelson		ADDRESS 1348 N. Calhoun St., Balto., Md.	
24a. REC'D BY REGISTRAR 30 '59		24b. REGISTRAR'S SIGNATURE William S. Kneass	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06665

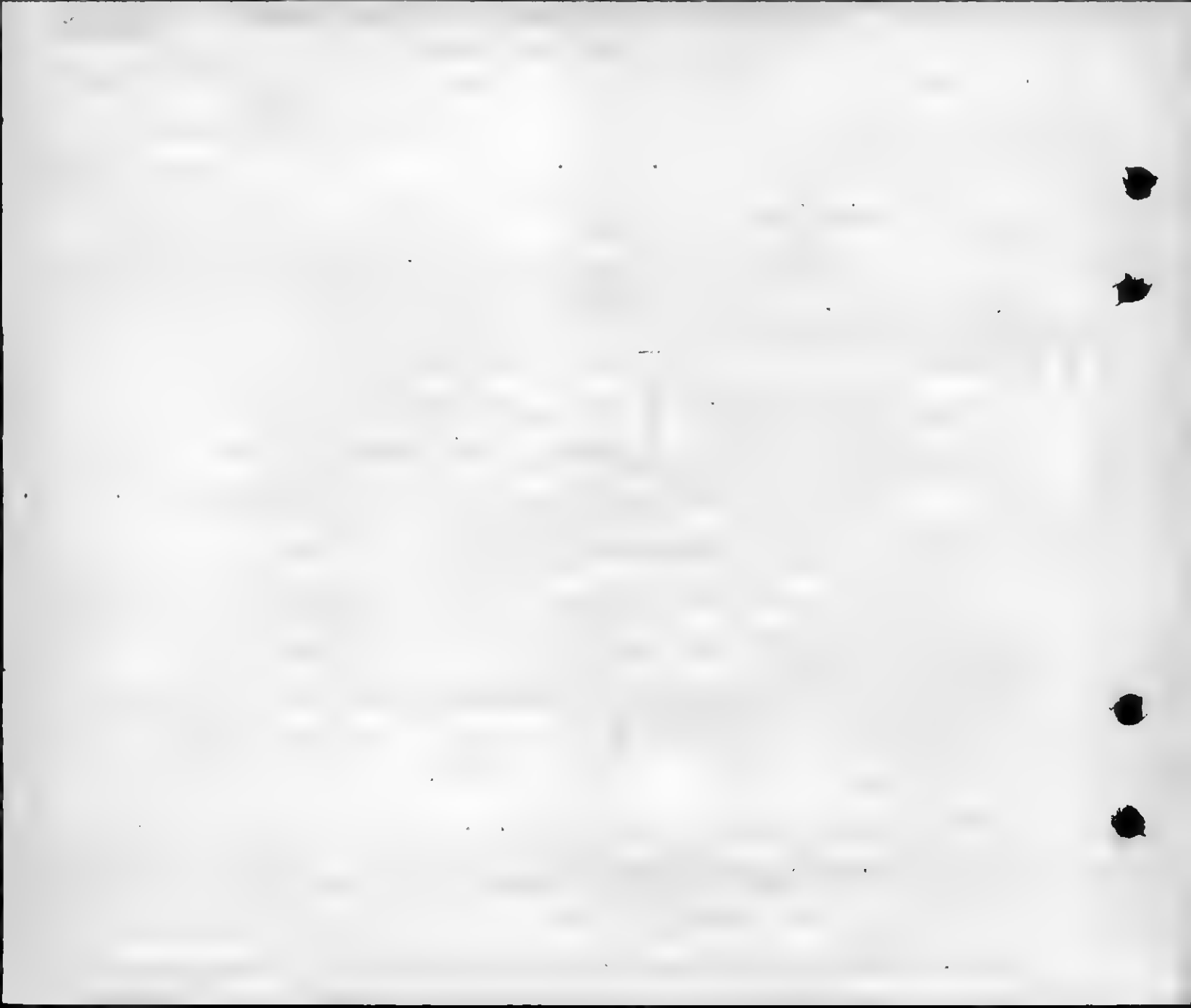
6681

CERTIFICATE OF DEATH

Reg. Dist. No.

97

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY <u>Plymouth</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>				c. LENGTH OF STAY IN 1b <u>1 hr. 50 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norwell</u> 58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S.N. Hosp.</u>				d. STREET ADDRESS <u>Washington</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lester</u> Last <u>Holland Jr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1959</u>		9. AGE (In years last birthday) yrs <u>1</u> <u>50</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Robert Lester Holland Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Irma delos Angeles Pina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 50 min.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. m.</u> <u>19</u> Month, <u>19</u> Day, <u>19</u> Year p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 June</u> , <u>1959</u> , to <u>10 June</u> , <u>1959</u> , that I last saw the deceased alive on <u>10 June</u> , <u>1959</u> , and that death occurred at <u>10:44 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Allen P. Hartman</u> M.D. <u>U. S. Naval Hospital, Bainbridge, Maryland</u> <u>6/11/59</u> PHYSICIAN'S NAME (Type) <u>ALLEN P. HARTMAN LT MC USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 June 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colora, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u> ADDRESS <u>PERRYVILLE, MARYLAND</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



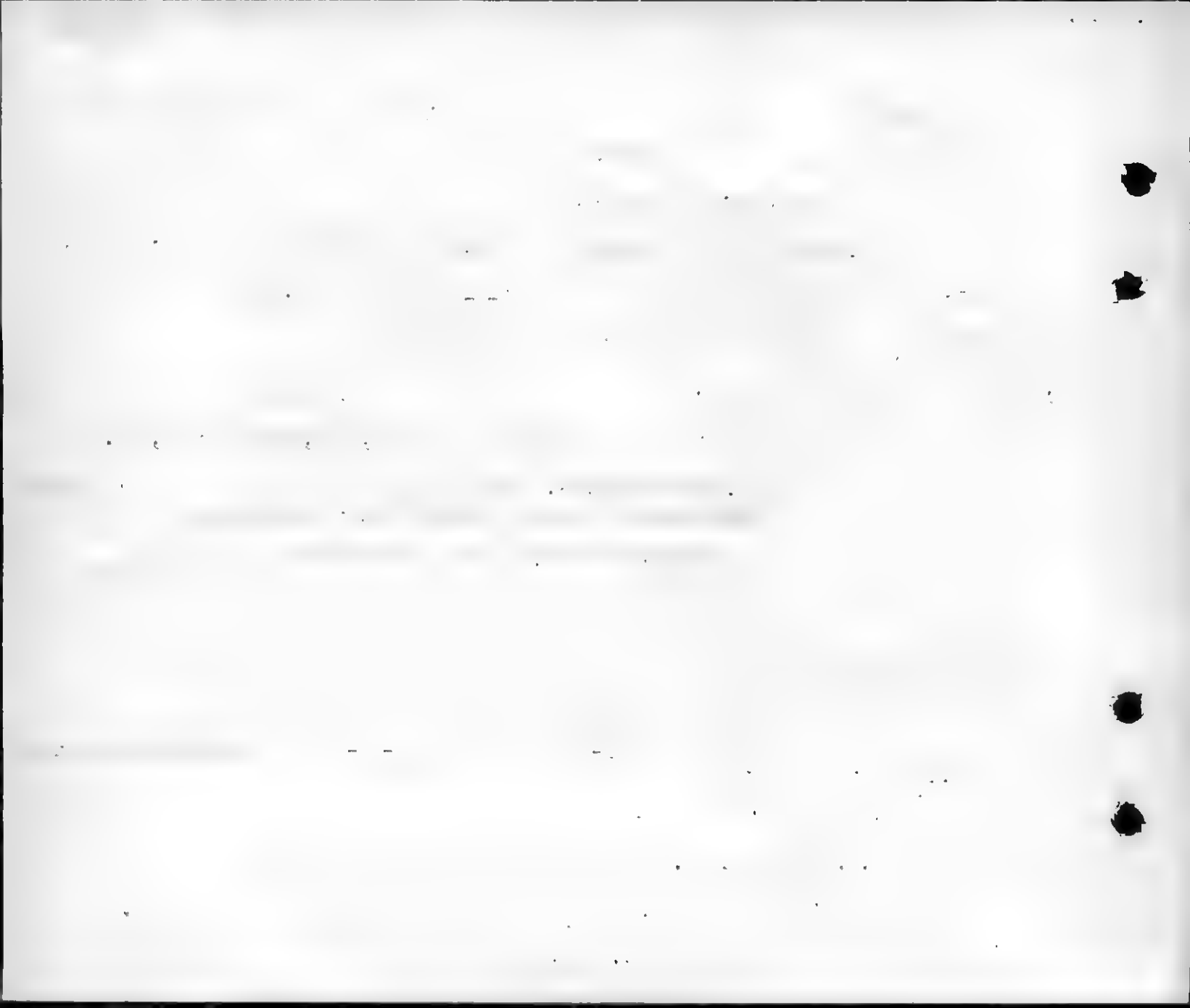
6682

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 23 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle WINFIELD Last JONES		4. DATE OF DEATH Month 6 Day 21 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-93
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)		10b. KIND OF BUSINESS OR INDUSTRY Farming (Own)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Jefferson Jones		14. MOTHER'S MAIDEN NAME Edith (Duvall) Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO Aspiration of foreign material (Food and Saliva) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Paralysis Agitans (Parkinsonian Syndrome), severe (c) severe		INTERVAL BETWEEN ONSET AND DEATH 4 to 6 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-3- 19 36 , to 6-21- 19 59 , and that death occurred at 9:35 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6/21/59 ACTUAL SIGNATURE S.P. LA CERVA M.D. PHYSICIAN'S NAME (Type) S.P. LA CERVA, MD., DIRECTOR; PROFESSIONAL SERVICES			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/59	
22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		22d. LOCATION (City, town, or county) (State) Leeland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie B. ...		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
ADDRESS Upper Marlboro, Md.		24b. REGISTRAR'S SIGNATURE Arthur J. ...	

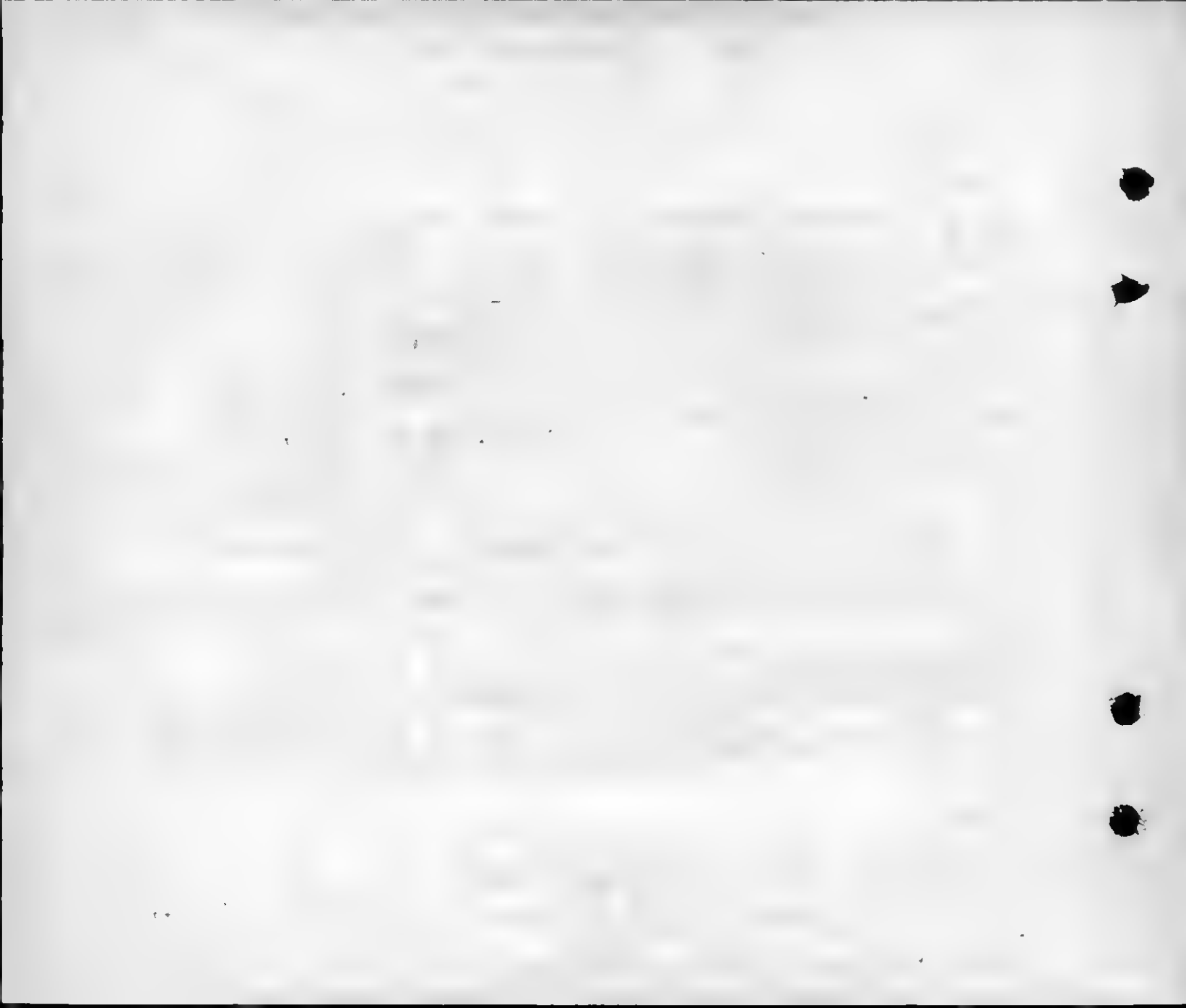
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



06662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikton		c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Baby Boy Logan		Middle Logan		Last Logan	
4. DATE OF DEATH		Month June		Day 29		Year 1959	
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-29-1959	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John P. Logan				14. MOTHER'S MAIDEN NAME Dorothy W. Widdekink			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT John P. Logan North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 716X DUE TO promotor infant. 5 mo. gestation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Promotor infant. 5 mo. gestation DUE TO (c) Promotor infant. 5 mo. gestation		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -					
20c. TIME OF INJURY Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that I attended the deceased from 29 June 1959 to 29 June 1959 , that I last saw the deceased alive on 29 June 1959 , and that death occurred at 4:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Md. DATE SIGNED 29 June 1959							
ACTUAL SIGNATURE Joseph H. Hochman		PHYSICIAN'S NAME (Type) Joseph H. Hochman M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-30-1959		22c. NAME OF CEMETERY OR CREMATORY North East Methodist		22d. LOCATION (City, town, or county) (State) North East Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6683

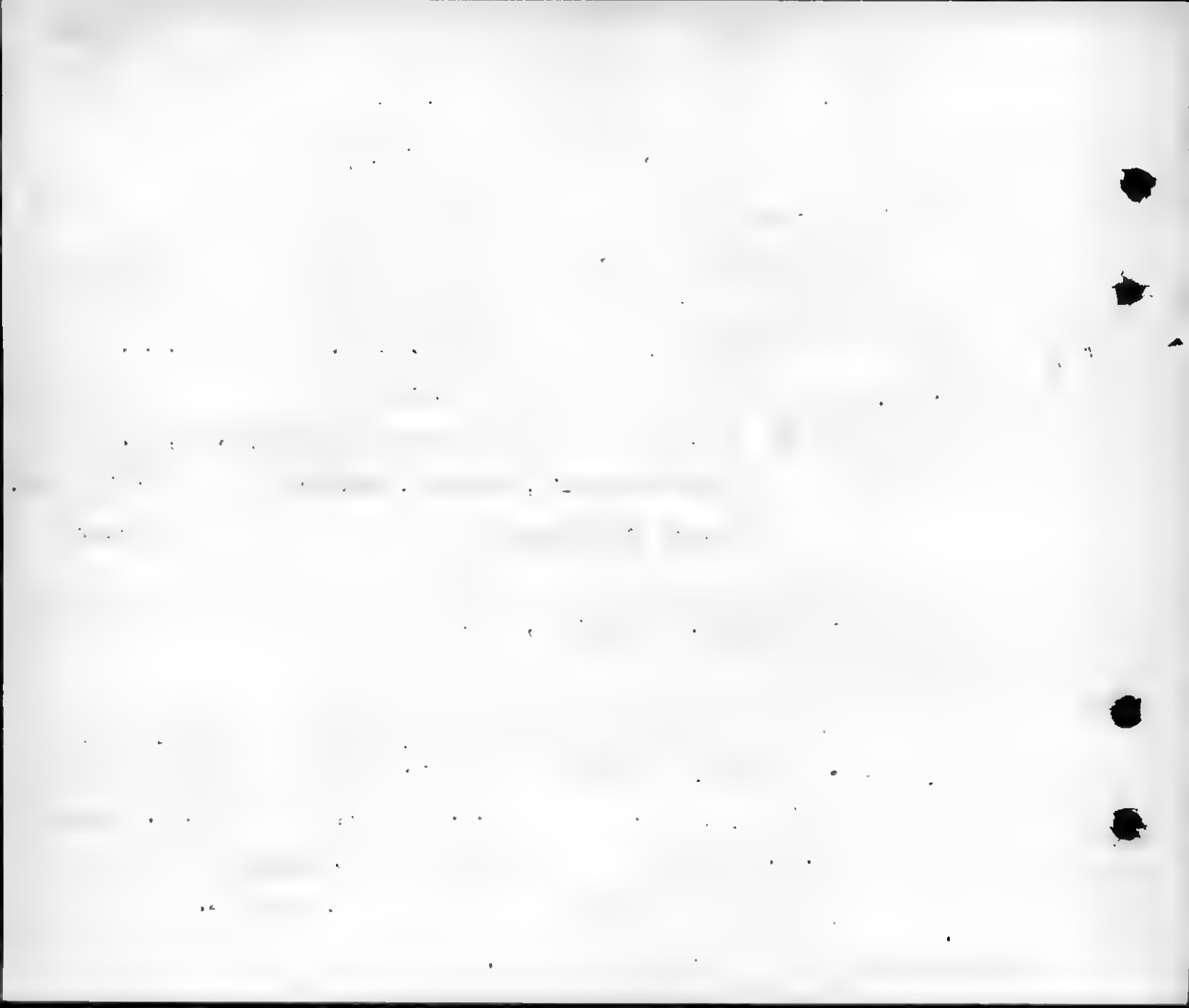
CERTIFICATE OF DEATH

06668

Reg. Dist. No. 96

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 4mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
f. STREET ADDRESS 7815 Exeter Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Melvin Middle T. Last Love		4. DATE OF DEATH Month 6 Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-95
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 20 Hours 19 Min 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doorman		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert K. Love		14. MOTHER'S MAIDEN NAME Nora Tippet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 577 10 0104	
INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved			
DUE TO (b) Plasma Cell Myeloma			
DUE TO (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-26- 19 59 , to 6-20-59 , 19 59 , and that death occurred at 1:30P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. L. GAREY		DATE SIGNED 6-22-59	
PHYSICIAN'S NAME (Type) J. L. GAREY		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 6/23/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myers, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Inc.		24a. REC'D BY REGISTRAR JUN 30 '59	
ADDRESS Havre de Grace, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital. The attending physician's signature is required. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

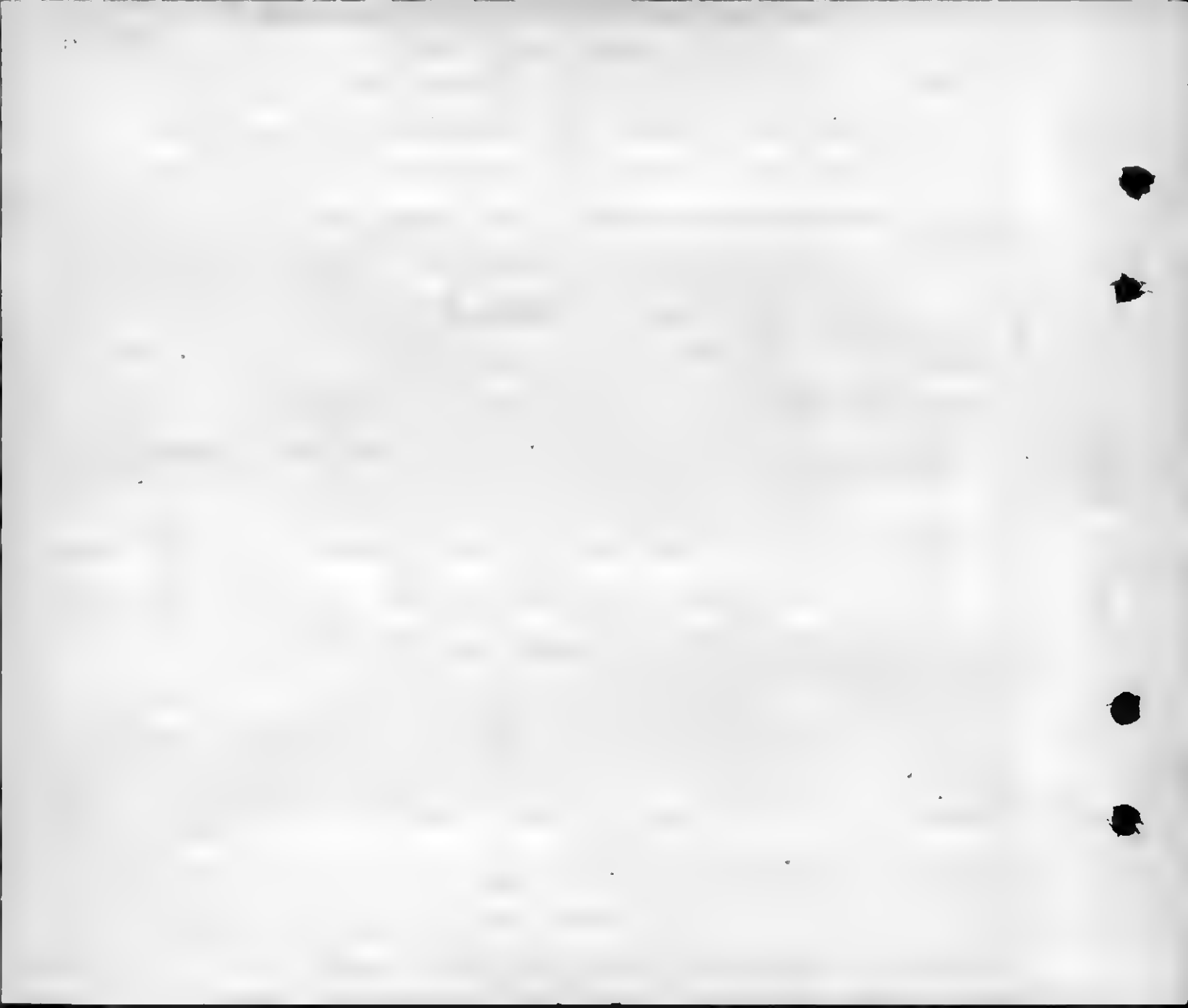
6666 CERTIFICATE OF DEATH

06669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>V.</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1906</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rudolph Moore</u>		14. MOTHER'S MAIDEN NAME <u>Emily Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-9051</u>	
17. INFORMANT <u>Mrs. Elizabeth M. Moore</u>		Address <u>Charlestown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>June 14, 1959</u> to <u>June 27, 1959</u> , that I last saw the deceased alive on <u>June 14, 1959</u> , and that death occurred at <u>10:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milford H. Sprecher</u> M.D.		DATE SIGNED <u>June 28-59</u>	
PHYSICIAN'S NAME (Type) <u>Milford H. Sprecher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	22d. LOCATION (City, town, or county) <u>Elkton, Maryland</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The form required that the deceased certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be attached for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

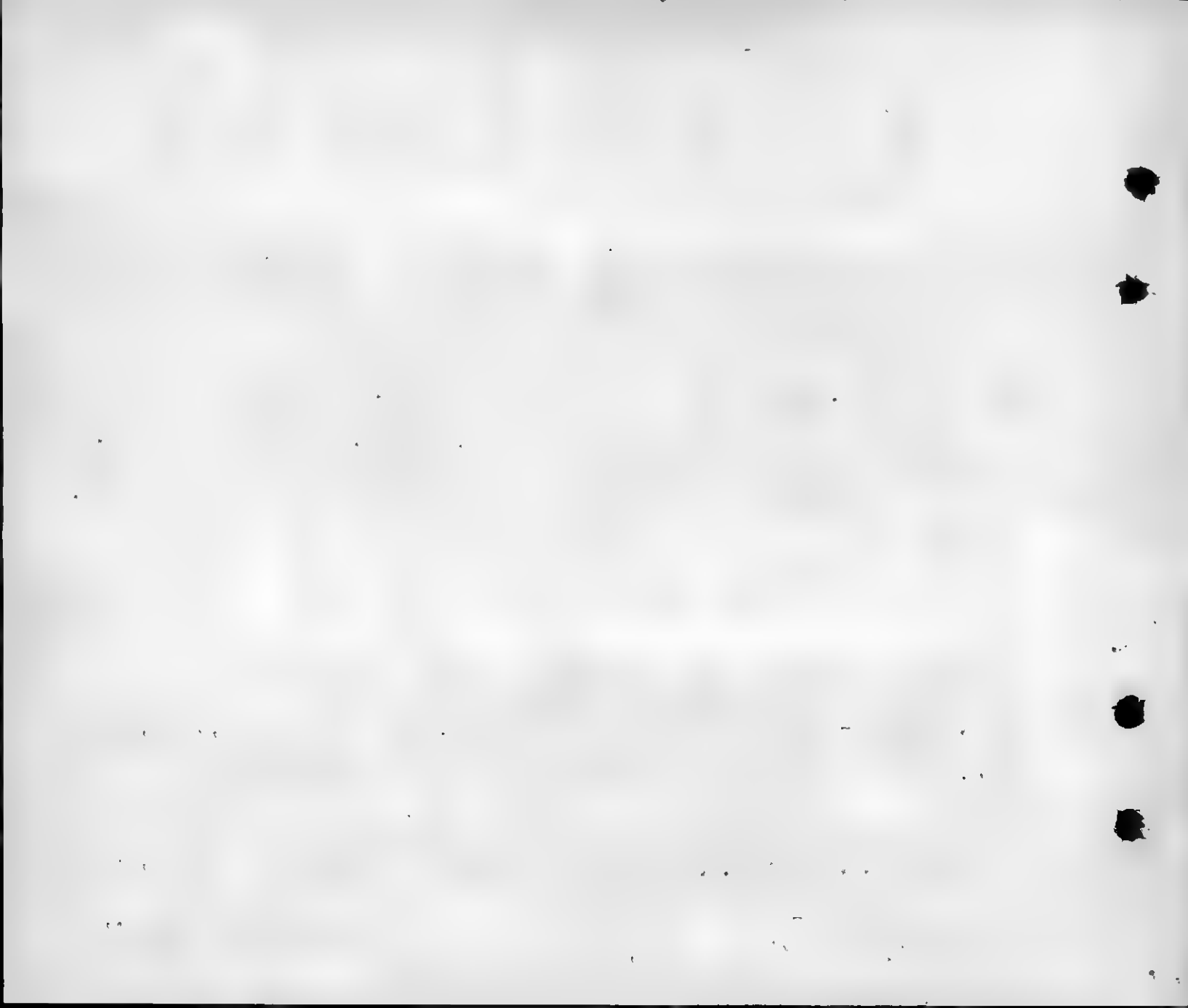


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06670	
Item 20b Film 244										6667	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rikton					c. LENGTH OF STAY IN 1b D O A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HMCN Hospital					d. STREET ADDRESS 1					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First George Middle Baory Last Norman			4. DATE OF DEATH Month June Day 9 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb 16 1904		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Boat Builder		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles E. Norman					14. MOTHER'S MAIDEN NAME Bertha M. Galloway						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			17. INFORMANT Address Mrs. Idella G. Jones, Charlestown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Slight cut on left forearm (c), stating the underlying cause last. DUE TO										INTERVAL BETWEEN ONSET AND DEATH 15 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car hit a concrete abutment							
20c. TIME OF INJURY Month, Day, Year 9-45 6-9 1959 Hour 9:45 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Charlestown Rt 267		20f. (City or town) Charlestown, Cecil, Md		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED June 10, 1959			
EXAMINER'S NAME (Type) R.C. Dodson M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-1959		22c. NAME OF CEMETERY OR CREMATORY Charlestown				22d. LOCATION (City, town, or county) (State) Charlestown Cecil Co., Md			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant						ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR JUN 12 '59		24b. REGISTRAR'S SIGNATURE Arthur A. ...	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6668

CERTIFICATE OF DEATH

06671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NR ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSP.</u>				d. STREET ADDRESS <u>R D # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HELEN PAYNE</u>				4. DATE OF DEATH <u>JUNE 12 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 10, 1923</u>		9. AGE (In years, last birthday) <u>35 1/2</u> yrs		IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MICHAEL KURILLA</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. STEC</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ROBERT A. PAYNE NR. ELKTON, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Marrow G. 7 Test Mononucleosis</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE LEUKEMIA</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. Month <u>—</u> Day <u>19</u> Year <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6:12</u> , 19 <u>59</u> , to <u>6:12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6:12</u> , 19 <u>59</u> , and that death occurred at <u>6:12 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Stalranis</u> M.D.				ADDRESS (Street, city or town, state) <u>134 W. MAIN ELKTON MD</u>		DATE SIGNED <u>6/12/59</u>	
PHYSICIAN'S NAME (Type) <u>PETER STALRANIS, M.D.</u>				<u>ELKTON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>IMMACULATE CONCEPTION - NR. ELKTON, MD</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>ELKTON, MD</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06672

6684

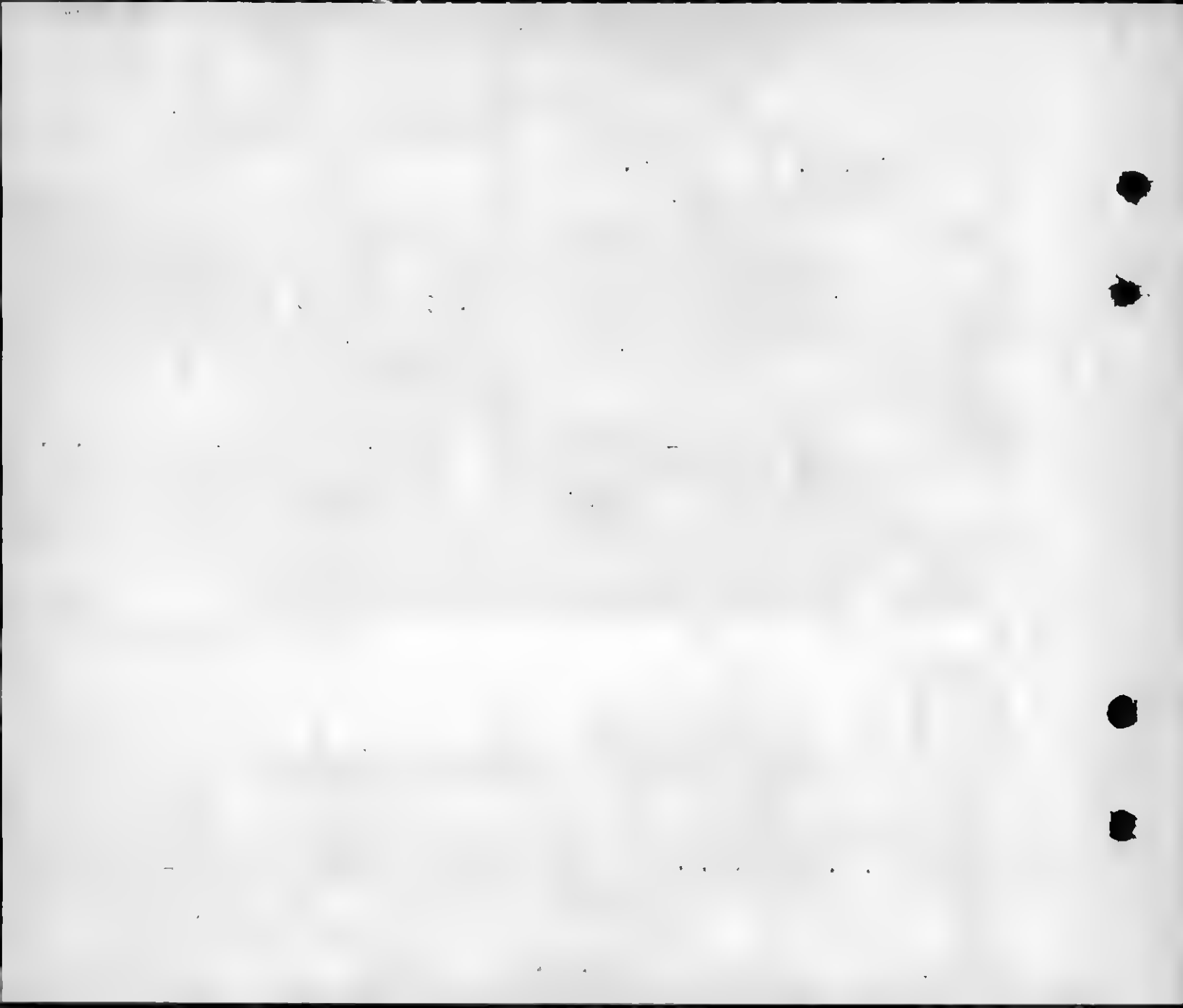
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS Aiken Avenue	
3. NAME OF DECEASED (Type or print) WILLIAM LEYBURN PERRY		4. DATE OF DEATH Month June Day 7 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1909
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY General repairs	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME REDDEN PERRY		14. MOTHER'S MAIDEN NAME VIOLA GAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. 218-18-1991	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, intraventricular right DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R. C. Dodson</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. DODSON, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6-7-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-8-59	
22c. NAME OF CEMETERY OR CREMATORY Principio Furnace		22d. LOCATION (City, town, or county) (State) Principio, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. A. Patterson</i> W. A. PATTERSON & SON, Perryville, Md.		24a. REC'D BY REGISTRAR JUN 10 '59	
		24b. REGISTRAR'S SIGNATURE <i>C. L. Kneale</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 10 days after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

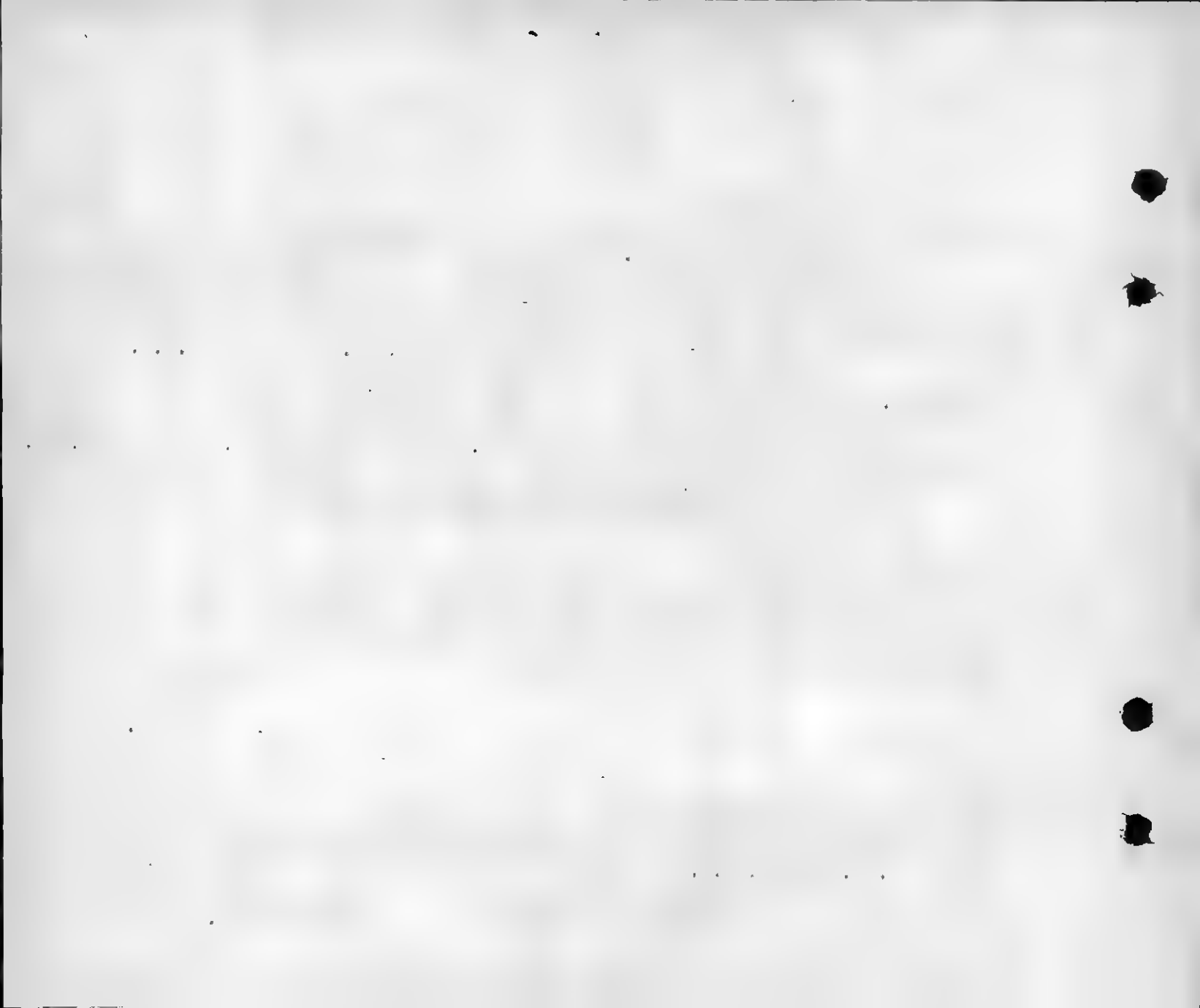
Reg. Dist. No.

06673

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS Rural Delivery		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First Drenerd Middle A. Last Reynolds </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month June Day 7 Year 19 59 </div>			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-25	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent	
10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Perryville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Drenerd M. Reynolds				14. MOTHER'S MAIDEN NAME Bertha Heverin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II		17. INFORMANT Address Not ascertainable Hosp. Records, VA Hospital, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 523X Billiary Peritonitis traumatic liver due to rupture of common duct DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 35%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH 16 days </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile hit a tree			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5-22 19 59 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RT 7	
20f. (City or town) (County) (State) North East, Cecil, Md.				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. DODSON, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 6-7-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-7-59 Removal				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY North East Cemetery	
22d. LOCATION (City, town, or county) (State) North East, Md.				23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph R Grant North East, Md			
24a. REC'D BY REGISTRAR JUN 9 1959				24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the registrar. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



6686

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Stewart		4. DATE OF DEATH Month June Day 7 Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Black		14. MOTHER'S MAIDEN NAME Hannah Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Horace A. Stewart		Address Port Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1959 to June 7, 1959 that I last saw the deceased alive on June 6, 1959 , and that death occurred at 6:10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. G.H. Richards Jr.		ADDRESS (Street, city or town, state) DATE SIGNED Port Deposit, Md. 6/8/59	
PHYSICIAN'S NAME (Type) Dr. G.H. Richards Jr.			
22a. BURIAL CREMATION, REBURY (Specify) Burial	22b. DATE THEREOF 6-10-1959	22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery	22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Sons		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE JUN 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6687

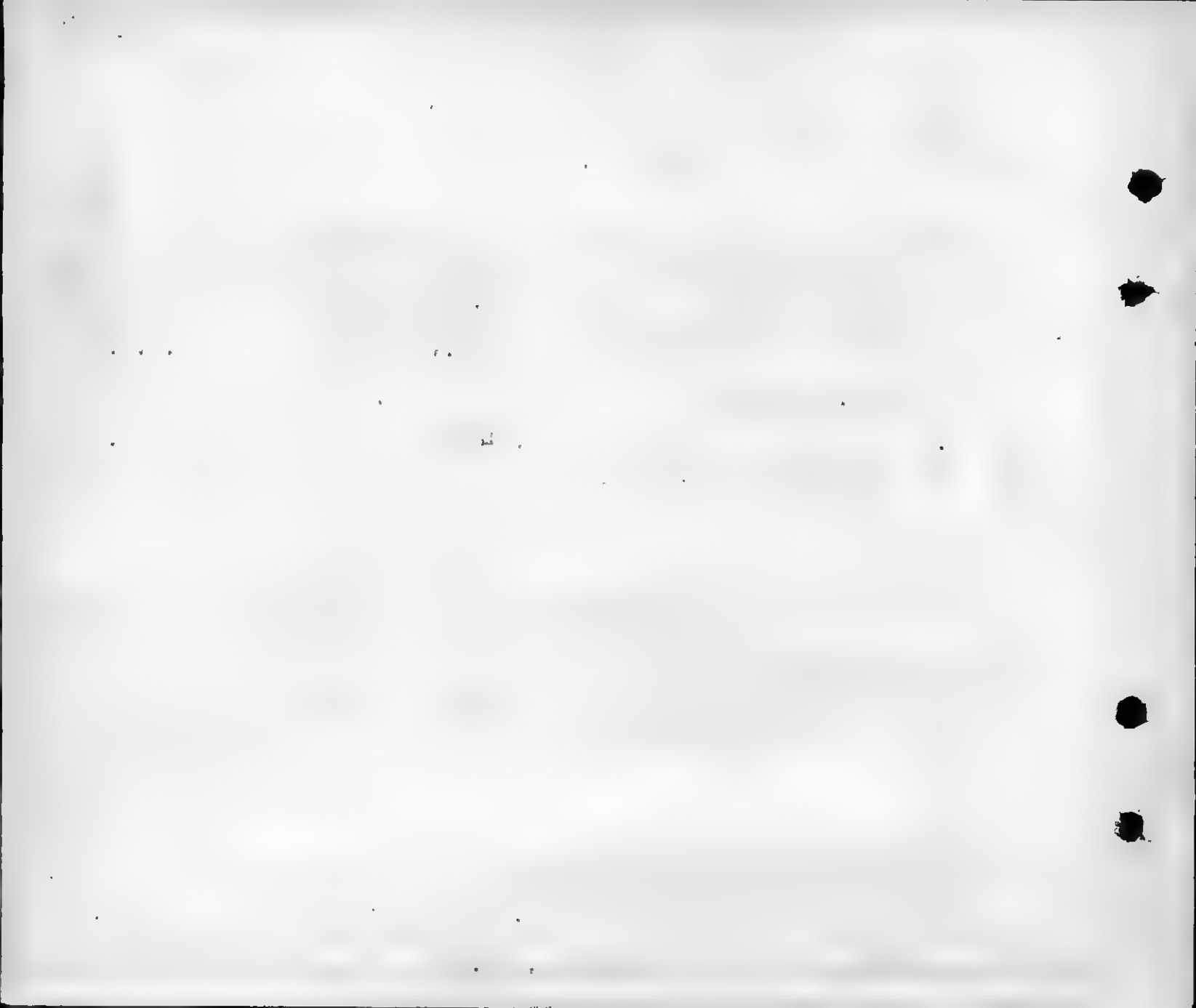
CERTIFICATE OF DEATH

06675

Reg. Dist. No.

1. PLACE OF DEATH Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cocolora		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cocolora	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Marian Haviland Tatum		4. DATE OF DEATH Month Day Year June 26 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1869
9. AGE (In years last birthday) 90		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11 BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Merritt M. Haviland		14. MOTHER'S MAIDEN NAME Lydia M. Haviland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Lloyd Balderston		Address Cocolora, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cerebral Sclerosis (b) Chronic Myocarditis (c) Arterio-sclerosis -		INTERVAL BETWEEN ONSET AND DEATH 6 weeks - 2 yrs 6 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5, 1959 to June 26, 1959 that I last saw the deceased alive on June 26, 1959, and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence J. Benson		ADDRESS (Street, city or town, state) Rising Sun, Md.	
DATE SIGNED 6/27/59			
PHYSICIAN'S NAME (Type) CLARENCE J. BENSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/1959	
22c. NAME OF CEMETERY OR CREMATORY Woodside Cem.		22d. LOCATION (City, town, or county) (State) Brinklow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas M. Mullen		ADDRESS Rising Sun, Md.	
24a. REC'D BY REGISTRAR DATE JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6669

CERTIFICATE OF DEATH

06676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>50 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>513 North Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carrie W.</u> Middle <u>Winsinger</u> Last <u>Winsinger</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1875</u>	9. AGE (If years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	IF UNDER 24 HRS. Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Newark, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Gray</u>				14. MOTHER'S MAIDEN NAME <u>Addelaide Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Margaret P. Biddle</u> Address <u>263 E. Main St. Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senescent arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Jan 1, 1959</u> to <u>June 26, 1959</u> , that I last saw the deceased alive on <u>June 24, 1959</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>June 26, 1959</u>							
ACTUAL SIGNATURE <u>Donald M. De</u> M.D. <u>Elkton, Md.</u>							
NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 28, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton, Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u> ADDRESS <u>Donald M. De</u> <u>Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6670

CERTIFICATE OF DEATH

Reg. Dist. No.

06677

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 403 North Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marvin E. Warmkessel				4. DATE OF DEATH Month Day Year June 14 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1900		9. AGE (In years last birthday) yrs. 59	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY U. of Del. Maintenance		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Warmkessel				14. MOTHER'S MAIDEN NAME Mollie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 221-01-3420		17. INFORMANT Address Mrs. Bessie Warmkessel, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 12	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14 1959 to June 14 1959, that I last saw the deceased alive on June 14 1959, and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED June 14 1959 ACTUAL SIGNATURE Dr. H. Sprecher M.D. PHYSICIAN'S NAME (Type) Dr. H. Sprecher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/59		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph E. Hicks Elkton, Md.				24a. REC'D BY REGISTRAR DATE JUN 22 '59		24b. REGISTRAR'S SIGNATURE Charles S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON R.D.2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON, R.D.2.</u>	
c. LENGTH OF STAY IN lb <u>20yrs</u>		d. STREET ADDRESS 	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WILLIAMS</u> Last			4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>19 59</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-1902</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Gardens and farm Va.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>George Williams</u>			14. MOTHER'S MAIDEN NAME 		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-93-1117</u>		17. INFORMANT Address <u>Mrs. George Williams Elkton, R.D.2 Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary OCCLUSION</u> <u>4-20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>				
ACTUAL SIGNATURE <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-25-59</u>
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>6-25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bohemia Manor Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Bohemia Manor, M d.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>909 Poplar St., Wilm. Del.</u>		24a. REC'D BY REGISTRAR <u>29 59</u>
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in 11 hours after death. If any delay is necessary, please enclose the certificate, writing thereon "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



6689

CERTIFICATE OF DEATH

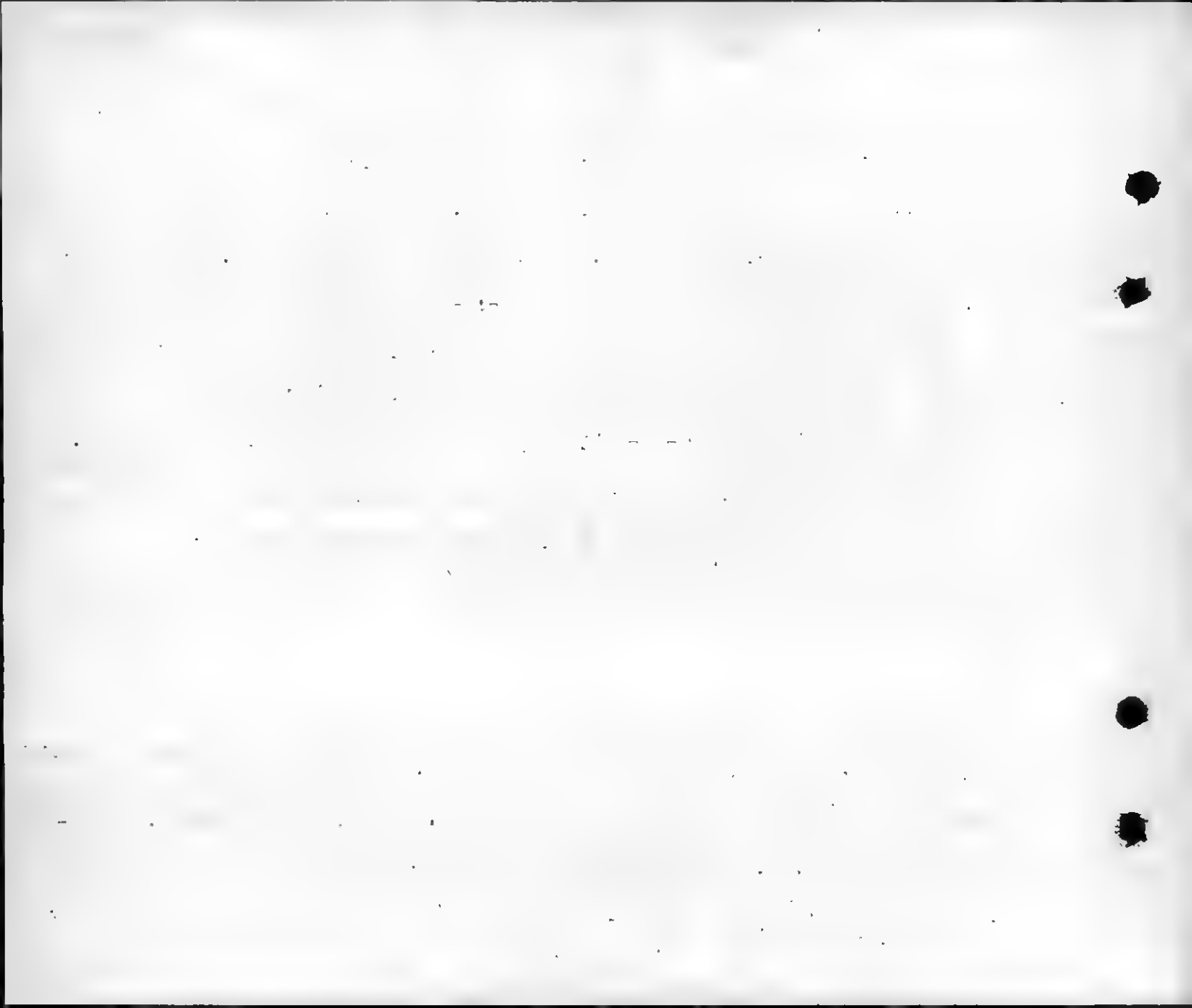
06679

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 25 N. Philadelphia Boulevard			
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last WILLIAMS				4. DATE OF DEATH Month June Day 15 Year 1959			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-92	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Williams (Deceased)				14. MOTHER'S MAIDEN NAME Sarah Busch (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-22-0605		INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis diffuse due to extravasated contents of viscera DUE TO (b) Resection of large bowel for adenocarcinoma of the rectum (6-12-59) DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 72 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 3, 1959, to June 15, 1959 and that death occurred at 8:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. L. Garey</i>				ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md.		DATE SIGNED 6-16-59	
PHYSICIAN'S NAME (Type) J. L. GAREY				Clinical Pathologist			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/1959		22c. NAME OF CEMETERY OR CREMATORY Wm. Waters Memorial		22d. LOCATION (City, town, or county) (State) Pooptown, Harford Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John P. Barry</i>				ADDRESS TARRING FUNERAL HOME, ABERDEEN, MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 18 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6690

CERTIFICATE OF DEATH

Reg. Dist. No. 96

06680

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke d. STREET ADDRESS 23X-2		
3. NAME OF DECEASED (Type or print) First Middle Last JESSE (NMI) WILSON			4. DATE OF DEATH Month Day Year June 26, 19 59		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH November 17, 1896		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unionville, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Levin Wilson			
14. MOTHER'S MAIDEN NAME Susan Hargis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI			
16. SOCIAL SECURITY NO. 217097293		17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pyelonephritis 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral Broncho pneumonia and lung abscess DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Years 2 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA		(County) (State)			
21. I certify that I attended the deceased from June 14, 19 59 , to June 26, 19 59 , and that death occurred at 9:40AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V. A. Hospital, Perry Point, Md. 6-27-59					
ACTUAL SIGNATURE B. Linn MD		DATE SIGNED DATE SIGNED			
PHYSICIAN'S NAME (Type) B. LINN, M.D.		Perry Point, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/28/59		22c. NAME OF CEMETERY OR CREMATORY UNIONVILLE	
22d. LOCATION (City, town, or county) (State) Pocomoke City, Md		23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON, Havre de Grace, Md.			
24a. REC'D BY REGISTRAR JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hines			

100-100000

Harry Jones
Harrison

12 June

Harry Jones

Geoff

Harry Jones

Wilson

(A1)

12 June

November 27, 1966

Male

U.S.A.

Washington

Labourer

James Harris

David Wilson

Harry Jones, 12 Hospital Road, VA Hospital, Harry Jones

12 June

12 June 1966

12 June 1966

x

100-100000

12 June 1966

12 June

12 June 1966

12 June 1966

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12 June 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for the registrar's use.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6671

CERTIFICATE OF DEATH

Reg. Dist. No. 06681

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union			d. STREET ADDRESS 120 Booth St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Madeline Middle B Last Young			4. DATE OF DEATH Month 6 Day 29 Year 1959		
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4 1882	9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR Months 7 Days 29 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Benjamin Biddle			14. MOTHER'S MAIDEN NAME Martha Sewell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 221-10-0190		17. INFORMANT Address Nora Braywood 120 Booth St Elkton, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 11 DUE TO (c) 11					INTERVAL BETWEEN ONSET AND DEATH 3 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 26 June 1959 to 29 June 1959 , that I last saw the deceased alive on 29 June 1959 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Klaus H. Huebner		M.D. North East, Md		DATE SIGNED 29 June '59	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-1959		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	
22d. LOCATION (City, town, or county) Elkton, Cecil Co., Md		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

